

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000009

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 10

FILED JAN 21 1963

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kirkville</u>		c. CITY OR TOWN <u>Kirkville</u>	
Length of stay in 1b <u>4 days</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Kirkville Osteopathic</u>		d. STREET ADDRESS <u>Rt. # 3</u>	
3. NAME OF DECEASED (Type or print) First <u>ROXY</u> Middle <u>LANEY</u> Last <u>CLIFTON</u>		4. DATE OF DEATH <u>January 11 1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never-married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/88</u>
9. AGE (last birthday) <u>74</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (City and state or country) <u>Macon County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S</u>	
13a. FATHER'S NAME <u>Samuel Story</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca UNK</u>	
14. NAME OF HUSBAND OR WIFE <u>Charles I. Clifton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates) <u>No</u>	
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Franklin Clifton, Kirkville, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>August 1961</u> to <u>January 11, 1963</u> and last saw her alive on <u>January 11, 1963</u> . Death occurred at <u>1-11-63 2:32</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Nathan Boone MD</u>		22b. ADDRESS <u>Box 100 Kirkville Mo</u>	
22c. DATE SIGNED <u>1-14-63</u>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 14 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Novinger</u>		23d. LOCATION (City, town, or county) <u>Novinger, Adair, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Foster Memorial Home, Kirkville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-12-1963</u>	
26. REGISTRAR'S SIGNATURE <u>Dorothy W. Ratliff</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

Permit issued Jan 14, 1963

DAVID W. BOONE, D.O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer, No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Nora E. Foster

Licensed Embalmer No. 4742

P. O. Address Berksville Md

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.